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| 附表17  |
| 基本医疗保险单行支付药品病种认定表 |
| 本人申请 | 姓名 | 　 | 性别 | 　 | 年龄 | 　 | 身高 | 　 | 体重 | 　 |
| 身份证号码 | 　 | 单位名称 | 　 | 医保编码 | 　 |
| 认定机构名称 | 　 | 参保地医保经办机构名称 | 　 |
| 申请认定的病种 |
| 　 |
| 认定机构意见 | 认定通过的病种 | 医生签章：年 月 日　 |
| 　 |
| 　 |
| 认定未通过病种 |
| 　 |
| 　 |
| 建议治疗方案 | 填表说明 | 　 |
| 药品通用名 | 　 | 　 | 　 |
| 药品商品名 | 　 | 　 |  | 　 |
| 剂量 | 　 | 单次用药剂量 | 　 |
| 频次 | 　 | 如每日一次、每周两次等 |  |
| 给药途径 | 　 | 如口服、静脉注射等 |  (公章) |
| 一次治疗周期天数（天） | 　 | 一次治疗所需的天数 |  | 　 |
| 治疗周期数 | 　 | 需要治疗的周期数 |  | 　 |
| 治疗周期（天） | 　 | 治疗周期=一次治疗周期天数\*治疗周期数 | 年 月 日 |
| 医保经办机构意见 | 1.通过病种认定的参保人员，应及时到定点医疗机构申请治疗，病种认定有效期为1年,认定到期后若还需要使用相应药品、认定后超过6个月未进行治疗或出现中断治疗达到6个月以上的,均应重新申请认定；2.认定机构需建签名台账或实行电子签名；3.此表可打印给参保人员留存；4.治疗周期（天）参照不超过《单行支付药品及高值药品适用病种及用药认定标准》中每个药品治疗评估周期，且不超过一个治疗年度。 |
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|  |  |  |  | 经办机构签章： |  |  |  | 　 |
|  |  |  |  | 认定通过时间 |  年 月 日 |
| 患者签名 | 　 | 联系电话 | 　 | 联系地址 | 　 |

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